STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: March 21, 22, 23, 24, and 25, 2011 Facility Number: 000553 Provider Number: 155660 AIM Number: 100267430 Survey Team: Kelly Sizemore RN, TC Marcia Mital, RN Sheila Sizemore, RN (March 21, 23, 24, and 25, 2011) Census Bed Type: SNF/NF: 47 SNF: 7 Total: 54 Census Payor Type: Medicare: 5 Medicaid: 28 Other: 21 Total: 54 Sample: 14 Supplemental: 4 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed on March 29, 2011 by Bev Faulkner, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=D	Based on record review and interview, the facility failed to ensure an allegation of misappropriation of a resident's property was reported to the Indiana State Department of Health in a timely manner, for 1 of 2 allegations of misappropriation of resident's property reviewed. (Resident #10) Findings include: 1. Review of an investigation, dated 12/23/10, indicated Resident #10's granddaughter reported the resident's wedding band was missing on 12/20/10. The investigation indicated on 12/23/10 the Administrator indicated she had "spoke to CNA (name) today & she made the statement that on 12-21-2010 (Resident #10's	F0225	F-225 Any and all alleged violations involving mistreatment, neglect, or abuse of residents including injuries of unknown origin and misappropriation of resident property will be reported immediately to the Administrator and other officials in accordance with State Law through established procedures (including to the State Surevey and Certification Agency). Notification to the Indiana State Department of Health , Adult Protective Services and the Area Ombudsman will be made with in a 24 hour time period of the reported incident.- All residents in the facility are identified as potentially affected by the deficient practice. timely reporting (with in 24 hours) to the ISDH, APS and area Ombudsman will occur by the Administrator or designee upon an allegation of a violation involving mistreatment, neglect, or abuse of a resident including injuries of unknown origin and misappropriation of resident property.- During the survey process, An in-service was given to all staff concerning the immdeiate notification of the Administrator or designee of any allegations of abuse or misappropriation of resident property. See attached in-service. The Administrator reviewed with the Director of Nursing, the Assistant Director of	04/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	name) sat on the edge of the bed and stated my ring is missing a girl took it off my finger at 3:00 in the morning..." During an interview on 3/22/11 at 3:30 p.m., the Administrator indicated the CNA had reported what Resident #10 had told her to her nurse. She indicated it was the evening shift on 12/21/10. She indicated the nurse had put the information on the 24 hour report sheet and she found out about what the resident had said when she came into work in the morning on 12/22/10. She indicated she was still considering the wedding ring a missing item and was already investigating. She indicated it was hearsay until she talked to the CNA. She indicated she had talked to the CNA on 12/23/10. She		Nursing and office personnel, the responsibilities of the person named as designee by the Administrator in her absence. The responsibilities are to include the reporting requirements to ISDH, APS and Area Ombudsman with in 24 hours of reported alleged incident.- Weekly the Administrator will keep a log for reported allegations of resident abuse or misappropriation of resident property. To ensure timely reporting the Administrive Assistant will monitor the log kept by the Administrator for timeliness of reporting to the ISDH, APS, and Area Ombudsman.(wih in 24 hours of alleged abuse or missappropriation of resident property).- The Administrator will report, to the Risk Management team weekly and to the Quality Assurnace team quarterly, the results of the allegation log and reporting time frames.- Completion date 4-24-2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated she reported the missing wedding ring on 12/23/10, three days after it was first reported. 3.1-28(d) .			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0226 SS=D	Based on record review and interview, the facility failed to follow their policy related to reporting allegations of misappropriation of residents property to the Indiana State Department of Health in a timely manner for 1 of 2 allegations of misappropriation of residents property reviewed. Findings include: 1. Review of an investigation dated 12/23/10, indicated Resident #10's granddaughter reported the resident's wedding band was missing on 12/20/10. The investigation indicated on 12/23/10 the Administrator indicated she had "spoke to CNA (name) today & she made the statement that on 12-21-2010 (Resident #10's name) sat on the edge of the	F0226	F-226 The policy relating to reporting allegations of missappropriation of residents property to the Indiana State Department of Health was reviewed and updated.- All the residents in the facility are identified as potentially affected by the deficient practice. - The ploicy relating to reporting allegations of misappropriation of residents property to the Indiana State Department of Health , Adult Protective Services and Area Ombudsman was reviewed and updated. The policy was presented to all department managers and front office personnel at the weekly Risk Management meeting. The policy to include specific time frames allowed for the reporting of an incident of alleged abuse or misapropriation of resident property. The incident must be reported no later than 24 hours post incident to the ISDH, APS, and area Ombudsman. A follow up report must be reported to the ISDH, APS, and area Ombudsman not later than 5 days following the initial report date. - All policies and procdedures will be annually reviewed and updated as needed, or as Federal and State regulations changes occur. The policy on reporting to ISDH, APS and area Ombudsman will be followed for all allegations of resident abuse or misappropriation of resident	04/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bed and stated my ring is missing a girl took it off my finger at 3:00 in the morning..." During an interview on 3/22/11 at 3:30 p.m., the Administrator indicated the CNA had reported what Resident #10 had told her to her nurse. She indicated it was the evening shift on 12/21/10. She indicated the nurse had put the information on the 24 hour report sheet and she found out about what the resident had said when she came into work in the morning on 12/22/10. She indicated she was still considering the wedding ring a missing item and was already investigating. She indicated it was hearsay until she talked to the CNA. She indicated she had talked to the CNA on 12/23/10. She indicated she reported the		property. Weekly, the Administrator will report to the Risk Management team the results of the log concerning timely reporting to ISDH, APS, and area Ombudsman. The initial reporting to be done wih in 24 hours of the incident. The follow up report should be sent within 5 days of the initial report sent.- Weekly results of the log will be reported to the Quarterly Quality Assurance Team at the Quarterly Quality Assurance meeting. Responsible person: The Administrator- Completion date 4-24-2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	missing wedding ring on 12/23/10. A facility policy, dated 9/08, titled "ABUSE PROHIBITION POLICY", indicated "...All reports or suspected or known abuse shall be reported to the...Indiana State Department of Health..." 3.1-38(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0253 SS=C	Based on observation and interview, the facility failed to ensure housekeeping and maintenance services were provided to maintain a sanitary and comfortable interior related to missing veneer, cracked light covers with bugs in them, dirty, leaking ice machine, dirty cabinets, trash can without a lid, dirty, marred, and scuffed doors, gouged walls, chipped paint, torn and dirty chair, and cracked ceiling tiles, for 4 of 5 halls, 1 of 2 dining rooms, 1 of 3 lounges (main dining room, main lounge, South, West, East, and North Halls.) This had the potential to affect 54 of 54 residents who reside in the facility. Findings include: During the environmental tour on 3/24/11 at 9:55 a.m. through 11:05 a.m., with the Environmental Director and Maintenance Director, the following was observed: Front Lobby: A buffet cabinet had a large water spot and missing veneer off of the top of the buffet. Main Dining Room: Two of five light covers were cracked and	F0253	F-253 Front Lobby - Buffet Cabineta. Maintenance sanded and refinished the surface of the buffet cabinetb. All wood surfaced furniture in the building will by checked and repaired for proper finish, in order to ensure a sanitary , orderly, and comfortable interiorc. Quality assurance checks will be done weekly for one month and then monthly on-going by the maintenance personnel. The maintenance director will oversee process to ensure sanitary, orderly, and a comfortable interior is maintained. the quality checks will be presented at the Quarterly Quality Assurance meeting.Main Dining Room - Light coversa. Two light covers wwere ordered and replaced b. All the light covers in the building were checked for cracks in the covers and replaced if neededc. Maintenance will be doing quality checks weekly for 1 month and then monthly on-going to ensure a sanitary, orderly, and comfortable interior. d. The Maintenance Director will oversee process and the quality checks will be presented at the quarterly Quality Assurance meeting.Lady Bugs in Light Covera. The light covers were cleaned and free of lady bugsb. All light covers in the building were checked for lady bugs and sanitary condition and cleaned if needed.c. Housekeeping will be cleaning	04/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	one of the light cover had six lady bugs in it. During an interview at the time of the observation, the Environmental Director indicated "looks like lady bugs" and "I see the cracks." The ice machine had water dripping from the ice dispenser and there was hard water buildup on the screen and drip pan. The bottom cabinet below the sink was dirty and had white crumbs. A trash can, with garbage in it, did not have a lid. During an interview at the time of the observation, the Environmental Director indicated it should have a lid on it. North Hall: Rooms N2, N3, N7 and N8, the entry way doors were marred and scuffed. Room N1, the wall behind the rocker had ten gouges. West Hall: Room W3 had paint chipping off inside both window frames. Rooms W4 and W6 entry way doors were		the light covers on a weekly basis to maintain a sanitary, orderly, and comfortable interior.d. Quality checks will be done weekly by the Housekeeping supervisor and presented to the quality assurance team at their quarterly meeting.Ice Macihne - Water dripping a. The Serviceman was called and the company advised us that some dripping occurs as the ice melts and that this is a normal function of this machine.b. No other ice machines of this nature are in the building. c. The inside of the machine is scheduled for cleaning every 3 months per manufacturer recommendations.d. Maintenance will be doing a visual check of the ice machine to ensure the dripping does not get worse in-between cleanings. and preform quality checks monthly to ensure a sanitary, orderly, and comfortable interior. These checks will be reported to the Quality Assurance team at their Quarterly meeting for one year. Ice Machine - Hard water buuild up on the screen and drip pana. The drip pan and screen were cleaned and the lime build up was removed.b. A quality check will be done on a weekly basis by Environmental Director for any other lime build up in the building. The lime build up will be removed and the equipment maintained.c. Housekeeping will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dirty, marred, and scuffed. Main Lounge: A cream color vinyl chair, had the right corner torn off and was dirty. The veneer was off the entire bottom of the fireplace along the edge. South Hall: The entry way doors to the clean and dirty utility rooms were dirty, marred, and scuffed. Room S1 entry way door had two gouges. Room S1B had four gouges on the wall behind the recliner. Rooms S4 and S6 entry way doors were scuffed and marred. Room S6, right outside the door in the hallway, the ceiling tile was cracked. East Hall: Room E2 the entry way door was marred. Room E4 the entry way door was dirty, marred, and scuffed.		be cleaning drip pan and screen on a daily basis with the product specific for the ice machine.d. Quality checks will be done weekly for one month and then monthly ongoing and reported to the Quality Assurance Team at their quarterly meeting.Cabinet under sinka. The area was cleaned by the housekeeping staffb. The underneath of all sink cabinets in the building were checked for sanitary conditions by the Environmental Director and cleaned if needed. c. The Housekeeping staff will be cleaning all cabinets under sinks on a daily basis to ensure a sanitary, orderly, and comfortable interiord. Quality checks will be done weekly for 1 month and then monthly ongoing by the Environment Director and reported to the Quality Assurance Team at their quarterly meeting.Trash Cansa. The trash can lids for 3 trash cans were ordered and replaced. b. All trash cans requiring lids were checked in the building by the Environmental Service Director and ordered if needed. c. Quality checks will be done weekly by the Environmental Service director for sanitary checks of the trash cansd. The quality checks will be presented to the Quality Assurance Team and their quarterly meeting. Entry Way Doors (N2, N3, N7, N8, W4, W6, S1, S4, S6, Clean and dirty utility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(f)(5)		rooms South Hall, E2, E4,)a. Entry way doors were cleaned and the gouges were filled with wood putty and sanded and refinished. Door protector sheets are bing ordered from Direct Supply to cover the bottom of the doors to prevent this from happening again.b. All the doors in the facility were inspected for deterioration and cleanlines. They were then cleaned and resurfaced if needed.c. Maintenance Director will check the condition of all the doors in the building weekly for 1 month then monthly on-going to ensure a sanitary, orderly, and comfortable interior. d. Maintenance Director will oversee process and report findings to the Quality Assurance Team at their quarterly meetings.Condition of walls and window frame (N1, W3, S1B,)a. Paint was scraped off if needed and dry wall mud was applied to the walls and and walls and window frame was repainted. Chair rails and wide crash rails were ordered for the damaged areas and for future damaged areas from Direct Supply.b. All the walls in the building were inspected for damage and if found in poor shape will be repaired and maintained and protected if needed.c. Maintenance Director will do a quality check of the walls and windows weekly for 1 month then monthly on-going to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			a sanitary, orderly, and comfortable interior.d. The quality checks will be presented to the Quality Assurance team at their quarterly meeting.Cracked Ceiling Tile outside room S6a. The tile was taken down and replaced. b. A check will be done on the conditioin of all ceiling tile in the building and replaced if needed.c. The Maintenance director will preform quality checks of ceiling tile weekly for 1 month then monthly on-goingd. The results of the quality checks will be presented to the Quality Assurance Team at their Quarterly meeting. Main Lounge - Vinyl chiara. The chair was cleaned by housekeeping staff and then removed from the building for repair.b. A check will be done on the condition and cleanliness of all resident chairs and furniture in the building weekly for 1 month then monthly on-going to ensure a sanitary orderly, and comfortable interior. the Chairs will be kept clean and in good condition. c. The Housekeeping Director will preform the quality checks and report the results to the Quality Assurance Team at their quarterly meeting.Main Lounge - Fire Placea. The fireplace veneer was sanded and refininshed by maintenanceb. All the wood furniture in the building was inspected and refinished if	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			needed by maintenance.c. Quality checks of the condition of the wood furniture will be preformed by the Environmental Director weekly for 1 month then monthly on-going.d. Quality checks will be reported to maintenance for required repairs and then reported to the Quality Assurance Team at their quarterly meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=G	Based on record review and interview, the facility failed to ensure a resident received adequate supervision and assistance to prevent accidents related to 1 (#42) resident being left unsupervised in the bathroom twice which resulted in a fracture and a laceration and failed to ensure interventions were in place for 1 (#13) resident which resulted in a fall for 2 of 7 residents reviewed with falls in a sample of 14. Findings include: 1. Resident #42's record was reviewed on 3/21/11 at 12:35 p.m. Resident #42's diagnoses included, but were not limited to, dementia with behavior disturbances, anxiety, and macular degeneration. A Significant MDS (Minimum Data Set) assessment, dated 2/11/11, indicated Resident #42's cognition status was severely impaired, required extensive assist of two staff for transfer, limited assistance of two staff for ambulation, and had prior falls. A fall risk assessment, dated 7/24/10, indicated a score of 17, placing the resident at a high risk for falls. A Nurses' Note, dated 9/1/10 at 11:20	F0323	F 323 - Free of Accident Hazards/Supervision/Device- Prior to the survey all staff signed acknowledgement of termination if found to have left a resident with fall risk and poor safety awareness unattended. This was added to new employee orientation.- During the survey a Star Program was put into place. Nursing Form #1. This was shared with the Survey Team prior to the survey completion.- Star Program -- indicating resident not to be left unattended in the restroom added to the care plans of those resident's who were added to the program. This program is ongoing. Added to new employee orientation. - A Fall Prevention In-service, in which fall prevention interventions and various situations r/t cognition were discussed, was conducted for all employees and has been completed. - Shared with the Surveyors prior to the completion of the survey was: All facility staff (during the survey) signed and acknowledged resident safety and interventions if noted to self remove an alarm. this also has been added to new employee orientation. Form #2.- Review of all current resident Fall Prevention Measures, Fall Risk Assessments, Personal Care Records and Care Plans will be reviewed and updates completed by : 04/24/2011. Will continue to review @ least quarterly.- The	04/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a.m., indicated "Found res (resident) lying on floor on stomach in room next to bathroom door. Res transferring self from toilet s/ (without) assist. Noted golf ball size bump to L (left) side of forehead et (and) abrasion to L eyebrow et to L wrist. C/O (complaint of) pain to hip/pelvic area. Res noted guarding hip/pelvic area. O/ (no) bleeding or further injury noted. O/ external rotation or shortening of (arrow down) (lower) extremities...." A History and Physical from the hospital, dated 9/3/10, indicated the resident was diagnosed with a left femoral neck fracture. A Post Fall assessment, dated 9/1/10, indicated the resident fell when attempting to transfer self from the restroom. The Post Fall assessment indicated the CNA had been suspended. During an interview on 3/23/11 at 1:10 p.m., the DoN (Director of Nursing) indicated a CNA had left the resident unsupervised in the bathroom. The DoN indicated the CNAs know if the residents are at risk for falls, not to leave the residents unattended in the bathroom. The DoN indicated the CNA left the room and the resident fell and fractured her hip. The DoN indicated the CNA was		Director on Nursing or designee to monitor falls and interventions/reductions daily in the stand up meeting, weekily in Risk Management and QA @ least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	disciplined for leaving the resident alone in the bathroom. A Nurses' Note, dated 3/8/11 at 7:30 p.m., indicated "CNA reported resident found lying on floor in her room. Resident lying in supine position on the floor. Resident yelling 'Oh my head' blood noted (arrow down) (under) resident's head. Resident reported 'on her way to bed.' Resident noted to have dry heaves et gently rolled to side c/ (with) pillow placed (arrow down) (under) head for alignment. Pressure applied c/ cold compress to back of resident's head...." A Nurses' Note, dated 3/8/11 at 10:00 p.m., indicated "Resident received staples x (times) 4...." A Fall Risk assessment, dated 3/8/11, indicated "...staff/CNA left resident unattended on toilet...." A care plan for at risk for falls, dated 6/24/10, lacked the intervention of not leaving the resident unsupervised while in the bathroom. A CNA Assignment Sheet, received from the DoN as current on 3/23/11 at 1:38 p.m., lacked documentation of not leaving the resident unattended while in the bathroom.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 3/23/11 at 1:10 p.m., the DoN indicated the CNA was suspended for leaving the resident unattended on the toilet. The DoN indicated the resident should not have been left alone on the toilet. The DoN indicated everybody had been educated in September not to leave the resident unattended in the bathroom.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=G	2. Resident #13's record was reviewed on 3/21/11 at 12:35 p.m. Resident #13's diagnoses included, but were not limited to, dementia, arthritis, and depression. An annual MDS assessment, with an assessment reference date of 1/25/11, indicated the resident was severely impaired with cognition, required limited assistance of one staff member for transfers, ambulation, and toilet use. The resident had fallen since the last assessment and had minor injuries. The resident's fall risk assessments, dated 1/13/11, indicated a total score of 13. The form indicated a total score above 10 represents high risk for falls.	F0323	F 323 - Free of Accident Hazards/Supervision/Device- Prior to the survey all staff signed acknowledgement of termination if found to have left a resident with fall risk and poor safety awareness unattended. This was added to new employee orientation.- During the survey a Star Program was put into place. Nursing Form #1. This was shared with the Survey Team prior to the survey completion.- Star Program -- indicating resident not to be left unattended in the restroom added to the care plans of those resident's who were added to the program. This program is ongoing. Added to new employee orientation. - A Fall Prevention In-service, in which fall prevention interventions and various situations r/t cognition were discussed, was conducted for all employees and has been completed. - Shared with the Surveyors prior to the completion of the survey was: All facility staff (during the survey) signed and acknowledged resident safety and interventions if noted to self remove an alarm. this also has been added to new employee orientation. Form #2.- Review of all current resident Fall Prevention Measures, Fall Risk Assessments, Personal Care Records and Care Plans will be reviewed and updates completed by : 04/24/2011. Will continue to review @ least quarterly.- The	04/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A care plan, dated 6/24/10, indicated "Resident is at risk for falls r/t (related to) dementia...1/13/11 Resident states 'feet came out from under her' Res (resident) confused at times...Encouraged to call for assist prn (as needed). Alarms added at this time...1/14/11 Resident removing personal alarm and getting up w/out (without) assist. Educated resident on risk and she acknowledged, still removes alarms r/t cognitive level..." The CNA assignment sheet, received from the DoN on 3/23/11 as current, lacked documentation to indicate the resident was at risk for falls or of any alarms used by the resident. The nurses' notes, dated		Director on Nursing or designee to monitor falls and interventions/reductions daily in the stand up meeting, weekily in Risk Management and QA @ least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1/13/11 at 6:30 a.m., "Called into res room. Res sitting on bed stating she fell...Swollen area 9 cm (centimeters) x 8 cm x 2.5 cm c (with) purple discoloration to rt (right) outer forehead/rt outer eyebrow area. Just below a swollen area measuring 3 cm x 2 cm x 0.2 cm skin colored. Reports some rt hip discomfort c walking..." The social service notes, dated 1/25/11 at 4:00 p.m., indicated "...Writer observed res walking down the hall later and she had her alarm in hand instead of attached..." The nurses' notes, dated 1/30/11 at 9 p.m., indicated "Res yelled 'Help!' Res found on her buttock on the floor of her room. She stated 'My feet slipped from underneath me.'			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Personal alarm did not alarm due to res removing alarm frequently..." During an interview on 3/22/11 at 4:45 p.m., the ADoN (Assistant Director of Nurses) indicated she was aware the resident had been taking off her alarms before the fall on 1/30/11. She indicated with the resident's cognition level they could educate but it did not do any good. She indicated if the resident was going to get up she was going to get up. She indicated after the second fall they changed the resident to a pressure alarm. During an interview on 3/23/11 at 1:35 p.m., the DoN indicated the CNA assignment sheets were not being updated.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155660	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HEALTH CARE CENTER	624 E 13TH ST WINAMAC, IN46996

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-45(a)(1) 3.1-45(a)(2)			